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Dear Dawn,
I appreciate the response from the DMH/COA review team regarding the recent application of Collaborative Solutions Corporation for a Certificate of Approval for out Williamstown project. I have reviewed the questions that have emerged from the team and respond to them as follows:

1) Operation of CRR impact on VSH census.

   The question of VSH census impact by the operation of this CRR, as well as a second one now in the early planning stages is only answerable in terms of what conditions will exist at the onset of our operations and in the next few years as the Futures Plan develops. I see two possible impacts from the current perspective of a CRT Director, and as a member of many of the Future sub-committees and the central committee as well. In both scenarios below the assumption would be that in taking long term rehabilitative patients from VSH, those beds would not then be used by new patients.

   The first impact I will regard as the least desirable, but possible one. In this situation I envision that the continued pressure on VSH to operate nearly at capacity and attempts are made to keep the 9 beds previously used by the now CRR residents closed to new patients. However, the pressure to use them could become overwhelming and perhaps 6 of the beds had to be used. Thus VSH would them have 53 beds in operation. This pattern could continue, and despite the CRR programs eventually taking 20 or more people out of VSH, there remains a need for 56 beds.

   I don't see this scenario as likely, but it could happen unless measures are taken at

the outset of the CRR operation, and unless the Futures plans for crisis and other beds are engaged quickly enough to stem the pressures on VSH. Assuming the system of care will rise to the occasion a second scenario becomes most likely.

The second impact scenario is one in which the 9 persons are taken out. VSH closes the nine beds, but operates as a 47 bed facility. As the CRR operations continue to expand, each long term rehabilitative patient is transferred to the CRR VSH closes the bed being used by that patient. Eventually there are no longer any long term patients in VSH who are stable but in need of specialized rehabilitation. As VSH has a new patient in need of rehabilitation they are referred to the CRR. The remaining CRR beds continue to be filled either by new VSH referrals or by getting the last of the remaining Brooks Rehab patients to the CRR. As the second CRR comes on line, the Brooks Rehab unit is closed or perhaps continued to be used to reduce crowding on Brooks I or II. VSH is then a 42 bed hospital. All future rehab referrals are made to the CRR's and the CRR's now are focused on placement of the former VSH patients.

The second scenario is only possible if we are indeed able to operate the 2nd CRR within another year, and that the system of care responds to a new need to see VSH only as a last resort. While the VSH census might always be 90% (of 42 beds) or so those, 38 beds would always leave a 4 bed margin. However, the creation of CRR's by itself will not be sufficient to keep pressure off of VSH as was indicated by the Milliman report. Unless all the systems change and additions are in place the CRR projects will only stem the tide in a system that has increased use of VSH overall.

2) Programmatic and Therapeutic Interventions

I hope to first convey to the team that the actual therapeutic interventions will be ones that emerge from assessment and trial and error with each resident. However, the overarching plan for these interventions will be imbedded within the programmatic structure, and treatment planning at the CRR. The staffing of the program is such that as well as medical staff, a social worker/case manager, a vocational worker, and peer support staff will be members of the CRR treatment team. Using the input of current VSH staff, and utilizing the CRR treatment team we will build a recovery oriented Individual Plan of Care (IPC) for each resident. These plans will reflect individual goals of a rather diverse group, in that some of the present VSH patients may only have a goal of a comfortable life outside of an institutional setting, but remain closely tied to provider supports. Others may want to be able to establish a highly autonomous lifestyle and pursue maximum independence from the provider system. For some the latter goal may be attainable, while for others such a goal may be a constant challenge due to relapse and frustration.

The achievement of these goals will be assisted greatly by a staff that will be recruited to reflect the apparent needs of the population. As well it is expected the

staff will be drawn from persons with experience in local DA programs, as well as VSH and other Designated Hospitals. CSC will be relying on experienced medical staff, both adept at the use of medication as a viable recovery tool, while concurrently able to recognize the importance other needs such as relationships, vocational desires, and resident internal strengths.

The in-house specialty social work and vocational staff will be a key feature of the program's ability to help facilitate the movement toward the goals of each resident's IPC. These staff will be charged with both addressing the immediate needs of residents—i.e. medical care, benefits eligibility, etc.—as well as developing placement options beyond the CRR or other plans

The daily needs of the residents will primarily be met through the efforts of the paraprofessional and peer staff. This group of staff will be configured to have a variety of experience in both medical and mental health care, with educational backgrounds ranging from high school to a four year degree level. It is expected that some staff will have be persons who have experienced recovery and be able to be both assistive and modeling for residents.

The CRR will endeavor to provide maximum support for residents with a self-management and personal choice as key guiding points. Services will be provided in a group setting as possible, but more likely will be offered as well in individualized formats to accommodate different learning styles. As well, residents will be encouraged to engage with the local community, and their community of origin to foster connectedness and encouragement of work or academic pursuits.

Staffing patterns will be adequate for individualized consumer care with a goal of 1 staff per 2 consumers (1:2 ratios) to allow for occupational, community, and activity time with staff as needed. Staff will be trained in:

- Trauma sensitive care provision
- Medication management
- CPR
- Co-Occurring Disorders
- Motivational interviewing and methods, and
- Crisis intervention methods to utilize conflict management techniques focusing on non-physical interventions. (This is likely to be NAPPI training.)

Staffing will be maintained at numbers to allow for any level of intervention necessary—4-5 staff available at anytime would be minimum. Additionally all staff will be provided recovery education, using the Mary Ellen Copeland model. Wellness Recovery Action Plans will be developed for each resident with both group and individual tutoring. The eventual outcome will be that at least one staff will serve as an in-house Recovery educator. Staff will endeavor to offer encouragement to all residents to function at their highest level possible and with a goal of the most independent lifestyle that can currently obtain.

The referral/admission/discharge information is best explained as an entire process. The referral process at the outset will primarily involve Brooks Rehab staff and CRR staff working together to identify and have clinical dialogue concerning current patients. This process has begun via a CSC staff engaging in this process in a more informal manner. The next step would be to have CSC staff attend treatment team meetings and begin a more overt planning process with staff and patients. Beyond the initial referral of patients in Brooks Rehab this collaborative process will establish itself with regular CSC consultation at VSH in order that possible referrals to CRR will be seen early enough to allow for discharge to the CRR at a time when patients might now be discharged to the Rehab Unit.

Patients who are admitted will be persons who have been deemed by VSH staff to meet the same criteria established for admission to Brooks Rehab, as well as some additional reflections supplied by the Futures related committees. The criteria for these patients are:

1. Non-Acute presentation (not in need of restraint/seclusion/involuntary meds)
2. Requiring monitoring and intensive support
3. May be refusing medication or other treatments, (This is in reference to situations where these are not deemed as absolutely necessary—i.e. patient can recover without them.)
4. Whose focus of care is recovery
5. Not able to have current needs met by other community programs
6. Substantial medical support/assistance with ADL's

(From T. Simpatico, MD - 8/3/04 Futures Meeting)

To flesh these out a bit more we would see this population as requiring extended care to gain a better hold on their recovery. It is expected these patients will exhibit symptoms associated with schizophrenia, schizoaffective disorder, major depression, bipolar disorder, and possibly Axis II disorders. At least in the early operation of the CRR we also expect there will be a need for supports for persons with cognitive disorders who have significant challenges to independent living, possibly for the rest of their lives.

The anticipated length of stay for residents will be from 6 months to 24 months, with a target of 12 months. The LOS is variable and discharge from the program will consistently be dependent on the recovery readiness of the individual residents. A significant issue for many residents may be finding adequate housing and supports in their home communities. Thus, the other variable to LOS will be the establishment of some individual placements for the residents who are ready for discharge, but require continued daily supports for successful living.

Discharge planning will be concurrent with admission to the program. Every effort will be made to maintain communication and treatment planning with the individual's current treatment providers, and to assist them in developing

appropriate care placements for the CRR residents. Resident's preference will be considered in all discharge plans.
Regarding implementation it is apparent that we can only open as soon as all permits, licensing, and hiring has occurred. At this time it would appear that actual opening day would likely be about October 15, 2006.

3) CRR Residents with Physical and Cognitive Disabilities

CSC clinical team has been reviewing patients in the Brooks Rehab Unit for over one month. It is our expectation that a small number of persons referred for the CRR will have needs for monitoring and significant assistance due to cognitive impairments. As well, some of the current patients also have limitations in movement and utilize assistance for mobility. Two of the bedrooms on the first floor of the CRR are modeled to be 100% usable for persons with physical disabilities. The remaining three bedrooms on the first floor will be primarily utilized for these patients. Thus we expect we will be able to provide adequate care for any person who has been inpatients in the Brooks Rehab as well as future referrals directly from Brooks I and II. Our direct care staff will be trained and supervised by medical staff familiar with the needs of this population.

4) Administrative Rate for Collaborative Solutions Corp

The 15% Administrative Rate will cover the following items:

- Contracted Billing Services to include billing, collections and related reports from providers billing system.
- Contracted Fiscal Oversight to include accounts payable, accounts receivable, development and implementation of accounting structure; monthly financial statement; budget development
- Payroll Services and Human Resources staff will also be contracted.
- Collaboration with Legal and Financial Counsel
- Management Information System – to include data collection and reporting
- Meeting space

Without these contracted Services, CSC would need to purchase/hire the following:

- Billing Software
- Accounting Software
- Data Collection Software
- Executive Director
- Chief Financial Officer and accounting staff
- Billing Manager and staff
- MIS Director or Outsourced MIS Services

If a second Residential Recovery Center is established, there will be some economy of scale and the overall Admin Percentage could be reduced from the current 15%.

I would offer the above responses with the proviso that we are discussing a program for which no existing model could be discovered, in a building that has yet to be renovated, operated by a staff that has yet to be hired. Thus, in short, we endeavor to operate the Williamstown CRR in the format of our COA application and this supplemental response. While we believe we are formulating our plans with a margin for error, we could easily need to adjust one or two areas or more. However, we know we have established a model here that it viable and has enough basis in current programming to be successful.

Please do not hesitate to contact me at 223-6328, 839-0332, or via email as might be needed to clarify any remaining issues.

Sincerely,

Michael Hartman
Development Director